# A STUDY OF FOUR ARTS ORGANIZATION-BASED ARTS AND HEALTH PROGRAMS

BY CARA SCHARF

# A STUDY OF FOUR ARTS ORGANIZATION-BASED ARTS AND HEALTH PROGRAMS

A Thesis

Submitted to the Faculty

of

Drexel University

by

Cara E. Scharf

in partial fulfillment of the

requirements for the degree

of

Master of Science in Arts Administration

December 2014

# DEDICATIONS

Dedicated to all the people who have supported me throughout my education, and all the amazing arts and health practitioners who have inspired me throughout my career.

## ACKNOWLEDGEMENTS

I owe a great deal to Dr. Jean Brody, my thesis advisor and director of the Drexel University Online Arts Administration Graduate Program, for providing invaluable insight and guidance for this paper. Most of all, she helped me to put many of my complicated thoughts into words.

I am thankful for the professionals who graciously offered their time and candid words to me as I was conducting my case studies. Also, I appreciate the incredible and important work that they and all arts and health practitioners are doing in the world.

To my parents and boyfriend, Will: thank you for allowing me to pursue my career-related and educational dreams. You set me on the path to where I am today, professionally and personally. To my professors and fellow classmates: thank you for sharing in this endeavor and pushing forward collectively. Without your encouragement at all stages in this thesis process and your willingness to think deeply with me, I may not have completed this work of which I am infinitely proud.

# TABLE OF CONTENTS

ABSTRACT ..... v

INTRODUCTION ..... 5
- RESEARCH QUESTIONS AND METHODOLOGY ..... 9
- LITERATURE REVIEW ..... 11

CHAPTER 1: FRAMING THE CASE STUDIES ..... 25
- THE PROGRAMS ..... 25
- ORIGIN STORIES ..... 28
- ORGANIZATIONAL CONDITIONS ..... 30

CHAPTER 2: SIMILAR AND DISSIMILAR CHARACTERISTICS ..... 32
- SIMILAR CHARACTERISTICS ..... 32
- DISSIMILAR CHARACTERISTICS ..... 35

CHAPTER 3: OTHER CONSIDERATIONS ..... 41

DISCUSSION ..... 45
- LIMITATIONS AND FURTHER RESEARCH ..... 48

CONCLUSION ..... 51

APPENDIX A: INITIAL LIST OF ARTS ORGANIZATION-BASED PROGRAMS ..... 54

APPENDIX B: MURAL ARTS LOGIC MODEL ..... 55

APPENDIX C: MURAL ARTS PRELIMINARY RESEARCH FINDINGS ..... 56

BIBLIOGRAPHY ..... 58

## ABSTRACT

This thesis explores four programs run by arts organizations that use the arts to improve some aspect of health. Case studies of the organizations showed that programs share common characteristics, such as being beneficial to the organizations as a whole, and that all program managers want to distinguish their work from clinical therapy. There are also significant differences between programs based on organization size funding; larger, better-funded organizations are more likely to value evaluation and partnerships with medical institutions while smaller organizations are more interested in running their programs to the best of their ability. This paper serves as a call to action for the arts and health field—urging them to examine the breadth and needs of arts-organization based programs, in addition to healthcare institution-based programs, in order to serve the field better as a whole.

# INTRODUCTION

It wasn't until a few years ago that I knew "arts and health" was a field. In 2008 I started a job at the Society for the Arts in Healthcare (now the Arts & Health Alliance) and discovered a vast world at the intersection of healing and creativity. I had the pleasure of learning about programs around the globe that were using the arts in unique ways to improve health and wellbeing. I saw people, from children with disabilities to young adults with cancer to seniors with dementia, who were transformed by their experiences with the arts.

But I also noticed disparities between arts and health programs in hospital settings and those in community settings, which were often run by arts organizations as opposed to medical institutions. From what I read and heard, arts organizations faced unique challenges when running health-related programs: namely, they do not have the clinical background or capacity that a healthcare institution has. The one large-scale prevalence study of arts and health programs in the United States, for instance, only took inventory of hospital-based arts and health programs—a task that was made vastly easier with the participation of the hospital accreditation organization the Joint Commission, which I am sure has more experience surveying its members than say Americans for the Arts or some other such arts service organization (Sonke et al. 2009). This prevalence study, which was commissioned by my former employer the Arts & Health Alliance, illustrates the organization's heavy focus on hospital-based programs, which could be due to many

understandable factors. First, hospital-based programs have more resources and money to give to the Alliance and, second, the Alliance places a high value on medical professionals who will validate the benefits of the arts in health.

Despite having fewer resources and not being in the spotlight, I continue to see arts organizations proliferate programs that use the arts for health-related purposes. I believe there are many reasons for this: for one, there is more professionalism in the field driven not only by the Arts & Health Alliance and other such organizations but also by new academic programs such as the Center for Arts in Medicine at the University of Florida, which was established in 1999, and a very recently established Arts in Healthcare Management concentration in the University of Oregon's graduate Arts and Administration Program. Later in this paper, I cite some main points from an interview I conducted with Patricia Dewey, the head of University of Oregon's program, and provide some information about a new prevalence study that one of the students in that program, Katie White, compiled for her graduate thesis. I also believe these programs are proliferating due to changes in the fields of healthcare and the arts, and I speak more about current trends in my literature review.

For these reasons, and because I am training to be an arts administrator myself, I chose to focus this thesis solely on arts organizations that run arts and health programs. I did not look at any hospital-based programs and the programs I did examine are run by artists and administrators who do not have medical backgrounds. I bring this up because, while working at the Arts & Health Alliance I experienced many tensions between the field's artist practitioners and clinically-trained expressive arts therapists (dance

therapists, music therapists, art therapists, etc.). For one, there is a lot of concern by clinically-trained therapists that the word "therapy" was being used to describe a wide variety of arts interventions that were not necessarily run by therapists, and that devalued their degrees. In this paper I address this and other issues, as they did, indeed, come up in my case studies. Personally, I believe that both clinically trained and non-clinically-trained practitioners can play a role in the field, and one of my case studies (Knoxville Symphony Orchestra) demonstrates a unique partnership between artists and a therapist.

I undertook this thesis because I am passionate about this field and want to see it grow, especially through the work of arts administrators like myself. Before I can convince arts administrators that arts and health programs are worthwhile, however, I need to understand how arts organization-based programs start and run, what challenges they face, and what successes they celebrate. Armed with this knowledge, I plan to start a conversation that might result in the field, at least in the U.S., becoming more united and driving growth in arts organization-based programs.

My thesis when I began this project was that, as arts organization-based arts and health programs become more prevalent, a set of common practices and issues is emerging and these must be shared widely in order for the field to grow effectively.

In studying four arts organization-based arts and health programs, I did find that they have some common practices and issues, but I realized that, far from there being a one-size-fits-all set of practices in the field, organizations have varying operational models that mirror their unique situations. In fact, I found quite a stark divide between the two programs that I studied from larger organizations and the two programs from

smaller organizations. This was a surprise, as I was not considering that organization size (and resources available based on size) would affect the program philosophies and administration—perhaps because At the Alliance we provided one-size-fits-all resources to all organizational members and did not consider that differently sized organizations or organizations from different fields would have different needs. Now I feel that it is imperative for service organizations in the field, such as the Arts & Health Alliance and smaller organizations that have popped up recently such as the Foundation for Art & Healing,[1] to know their audiences and recognize the full scope of the field. Not all organizations value the same things that the service organizations value, such as research, evaluation, and standards. There are several different ways to support arts-organization based arts and health work. The field is still extremely young and perhaps more needs to be understood about it and the people in it before the service organizations can forge ahead.

## RESEARCH QUESTIONS AND METHODOLOGY

To find out if common practices exist in how arts organizations start and run health-related programs, I set out to answer questions such as:

- Why do arts organizations initiate health-related programs?

[1] Founded in 2009 by a doctor and Harvard University public health professor, the Foundation for Art & Healing's mission works to bridge the worlds of arts and medicine by promoting and sharing research, disseminating knowledge about arts and health practice, and running programs. More on their website: http://www.artandhealing.org.

- How do arts organizations define their health-related programs, and how do they fit into the organization's arts-based mission?
- How are programs crafted? How do arts organizations articulate the outcomes they wish to achieve, without clinical backgrounds? How are programs evaluated?
- How do organizations define success outwardly, and, internally, how do they benefit from running these programs?
- What major challenges do arts organizations face in regard to running health-related programs?

My first research step was compiling a list of programs that fit my parameters of being health-related programs housed in arts organizations whose missions were primarily artistic, as opposed to the missions being focused on arts and healing. I came up with a list of 25 programs (which I will include in my Appendix), and from there chose 4 for case studies. I varied the organizations by location, art practiced, and other variables in order to see if there are common threads in disparate programs. The programs I examined (and my interviewees) are detailed in Chapter 1 of my research. For each case, I conducted phone interviews with the program director and, for 3 out of the 4 case studies, I also interviewed auxiliary representatives, including board members, artistic directors, and other staff members. My aim was to get a well-rounded sense of how leadership and other stakeholders view and talk about the program.

After my case study interviews were finished, I wrote an initial list of common themes and discussed these with an overarching field professional, Patricia Dewey, who

as I mentioned before is the head of the Arts and Administration Program at the University of Oregon. She recently created a concentration in Arts in Healthcare Management for that program, which I felt made her a good resource.

## LITERATURE REVIEW

Work in the field of arts and health has been described in many different ways by many different organizations and practitioners. In 2002, the Center for Arts and Humanities in Health and Medicine (now known as the Center for Medical Humanities) at Durham University in the United Kingdom defined arts and health activities as "creative activities that aim to improve individual/community health and healthcare delivery using arts based approaches, and that seek to enhance the healthcare environment through the provision of art works or performances" (White 2002, 11). In 2005, the same author, Mike White, defined the practice of arts in health as "comprising all activities that aim to use arts-based approaches to improve individual and community health, health promotion and healthcare, or that seek to enhance the healthcare environment through provision of artworks or performances" (Macnaughton, White, and Stacy 2005, 333). In 2008, author and practitioner Bernie Warren defined "creative therapy" as "the use of the arts and other creative processes to promote health and encourage healing" (Warren 2008, 8).

In 2009, board members and other prominent members of the Arts & Health Alliance, including Jill Sonke from the Center for Arts in Medicine at the University of Florida, published "The State of the Arts in Healthcare in the United States," the first prevalence study to look at the United States arts and health landscape (though, as I mentioned before, it only detailed the prevalence of hospital-based programs). That group defines the purpose of arts and health as "to use creative activities to lessen human suffering and to promote health, in the broadest sense of the word" (Sonke et al. 2009, 107). In 2011, the Arts & Health Alliance revised the definition of the field to "arts and health is a diverse, multidisciplinary field dedicated to transforming health and healing though the arts. The field integrates literary, performing, and visual arts and design into a variety of healthcare and community settings for therapeutic, educational, and expressive purposes" ("Arts & Health" 2011).

These definitions share several commonalities, one of the most prominent being that they are extremely broad even as they are refined through the years. In my personal experience with the Arts & Health Alliance, the definition is broad so as to remain inclusive of many kinds of practitioners and programs. They are a membership organization dependent on earned membership revenue, and they aim to bring together as wide a base of members as possible. This may also be a byproduct of the field's youth—there is not yet a large enough following to warrant splitting the field into subsections, though I do argue later in this paper that this might be beneficial, due to the specific nature of the wide-ranging activities that go on in the field. (Here I should also mention that the arts and health field has a lot of overlap with the field of public health—the arts

can and do play a large role in health education and crisis management—but that is not going to be included in my research.)

Another common theme in the literature is the need to differentiate between work done by non-clinicians and work done by expressive arts therapists, including music therapists, dance/movement therapists, and art therapists. These clinically-trained practitioners work within a medical model of diagnosis and treatment, while projects not involving therapists generally view the process of creating and interacting with art as therapeutic in and of itself ("Creative Minds in Medicine" 2014). Some of the literature also states that therapists work toward individual outcomes while non-clinical arts and health work is more focused on communal and systematic change (White 2009).

The growth of the arts and health field (as I will refer to it from here on out) has been fueled by two movements: one within the arts field that seeks to prove the instrumental value of the arts and one in the health field that seeks to define treatment as not just curing illnesses but also caring for a complete person. As the value of the arts was called into question during times such as the Culture Wars in the early 1990's, arts organizations have responded by saying the arts are not simply necessary for culture but that they also have tangible benefits in areas like education and economics (McCarthy et al. 2001). These benefits are described as "instrumental" and differentiated from "intrinsic" benefits of arts participation (McCarthy et al. 2001). An example of an organization that has capitalized on this movement is the Center for Performance and Civic Practice. Started by theatre artist Michael Rohd, this organization promotes the role of the arts in building civic engagement by developing best practices for cross-sector

projects that involve both an arts organization and a non-arts partner but are driven by the goals of the non-arts partner. The organization's website says, "artists engage in this work around the nation with regularity, but due to the frequent low visibility of these projects and a scarcity of shared vocabulary, the way we integrate them into ongoing national cross-sector dialogue is severely limited" (The Center for Performance and Civic Practice 2014).

In the health field, the last several decades have seen a movement toward a more balanced definition of health, not just as the absence of disease but as total well-being (Sonke et al. 2009). Mike White references the changing priorities of public health and the World Health Organization from only biological determinants of health to biological and social determinants of health together (White 2009). In the United States, the Department of Health and Human Services defines a strategic goal as to "advance the health, safety, and well-being of the American people" (Hanna 2011, 10).

Researchers Heather Stuckey and Jeremy Noble echo these ideas, writing that "globalization"—specifically taking into account worldwide cultural practices when providing healthcare across the globe—and a new focus on community-based health work are sending more attention to the arts as a viable supplement to traditional medical interventions (Stuckey and Nobel 2010). Their paper is also a literature review, pulling together the evidence that exists in the medical field showing the arts actually do produce health benefits. For example, one study showed that listening to music can effectively lessen chronic pain in cancer patients, and another showed that having art in a hospital

environment can reduce the length of time a patient needs to stay in the hospital (Stuckey and Nobel 2010).

As the arts and health field grows, some researchers have attempted to document commonalities and best practices through field-wide studies. Two such studies came from the United Kingdom and were commissioned by government entities interested in exploring community-based arts projects as a tool for improving health. The one U.S. study is the Alliance for Arts & Health report, which I have mentioned several times already for its focus on hospital-based programs.

The first United Kingdom study, conducted by the National Health Service, gathered information from 90 arts organizations throughout the U.K. that were running arts projects meant to achieve not only health outcomes but also health education and community connectedness ("Art for Health: A Review of Good Practice in Community-Based Arts Projects" 2000). Researchers then did case studies of 15 projects, and published their findings in 2000. The purpose of the research was to gather information about how programs functioned and develop a set of recommendations for running programs. I have noted some of their key findings later in this literature review.

The second United Kingdom study led by Sue Hacking in 2006 surveyed 230 organizations that were involved in projects using the arts to improve mental health. The survey received 116 responses and 102 projects met the researchers' criteria of being a participatory arts project for people between the ages of 16-65 with mental health needs (Hacking et al. 2006). Survey questions were about funding and staffing levels, what art

forms were utilized and what specific patient populations were involved, where the projects took place, and whether and how data was collected about outcomes.

The Arts & Health Alliance's 2009 U.S. prevalence study surveyed all accredited hospitals in the country to ask whether they had arts programs, what types of arts programs they had, how the programs were financed, what benefits the programs produced for the hospital, and whether and how the arts programs were being evaluated. The report draws on two surveys, one sent in 2004 with 2,333 respondents and one sent in 2007 with 1,807 respondents. In the 2004 study, 43% of respondents said they had arts programs while 49% said the same in 2007 (Sonke et al. 2009, 114).

There are also sources featuring more local case studies. I found one city-based report about arts and health activities in the Cleveland, Ohio region, published by a non-profit that advocates for cross-sector collaboration called the Community Partnership for Arts and Culture. Another United Kingdom report, titled "Arts, Health, and Community," details the functioning of 5 community-based arts and health programs.

When looked at overall, it is apparent there is no prevalence information on the specific niche I am researching—programs run by community arts organizations without clinical practitioners. In my research, I did come across a student, Katie White, in the University of Oregon Arts and Administration Program, who wrote a thesis in 2014 attempting to create a geographic map of arts and health activity and resources in the United States. Her map has 90 entities as of October 25, 2014.[2]

[2] White's map is still viewable here: http://placestories.com/project/145991.

In general, the reports reveal that a number of arts and health programs share common traits, philosophies, and challenges. One commonality was that arts and health programs are extremely diverse, making it difficult to define them in any singular way. Most studies categorized programs by the type of art done and the method used in the program, such as whether it was a class conducted by a teacher or a participatory arts project. The study by Hacking et al. indicated "no single way of categorizing projects proved watertight. The majority of projects were clearly hybrid in nature, operating flexibly and supported by a variety of funding sources" (Hacking et al. 2006, 123).

Programs also tended to work toward more socially-based and quality-of-life related outcomes than medically-based treatment outcomes for specific ailments. The programs that Hacking et al. surveyed, for instance, said that the most common and important outcome of their programs was improved self-esteem (Hacking et al. 2006, 125). The report by the National Health Service showed that, when surveyed projects were asked what outcomes they produced, most respondents said increased happiness and 91% said that the program contributes to health by developing self-esteem ("Art for Health: A Review of Good Practice in Community-Based Arts Projects" 2000, 17). The 2005 paper by Mike White and others, "Researching the Benefits of Arts and Health," said that it is difficult for community-based arts and health programs to bridge the gap between social benefits and medical benefits such as life expectancy and lower instances of chronic disease. They write "it is not the arts activity alone that provides health gain—rather how it is delivered; and the environment and conversations around the activity

provide the intermediate indicators of perceived benefit" (Macnaughton, White, and Stacy 2005, 336).

Many sources even spoke about the dangers of trying to over-professionalize or create rigid standards in the field, mainly because programs are so diverse, tied to the specific needs of the communities within which they operate, and meant to be creative and flexible:

> Perhaps the greatest challenge now for these projects is not to be drawn into statutory responsibilities and professionalised or bureaucratised service provision which may serve to stifle creativity and inappropriately shape the features of arts in health projects in community settings (Everitt and Hamilton 2003, 54).

Some thinkers in the arts and health field also have negative feelings toward medically-modeled structures, which seem to go against the principles of the arts. Healing arts practitioner Bernie Warren claims in his book that it is detrimental to hold the field of arts and health to the same standards of the medical field, because it hampers artists' ability to focus on what is unique about the healing qualities of the arts (Warren 2008).

Only one study specifically talked about the aesthetic quality of the art produced in arts and health programs. The report by the U.K.'s National Health Service found through site visits that artistic excellence was important to arts and health practitioners ("Art for Health: A Review of Good Practice in Community-Based Arts Projects" 2000, 25). Researchers also discovered that it was important to market arts and health programs

using the art first, rather than the health benefit they were working to produce ("Art for Health: A Review of Good Practice in Community-Based Arts Projects" 2000, 26).

Common challenges were also reported in many of these studies; funding was one. Of the organizations surveyed for the National Health Service report, 39% cited funding as the greatest challenge ("Art for Health: A Review of Good Practice in Community-Based Arts Projects" 2000, 18). Hacking et al.'s study found that, for organizations surveyed, funds were patchy because they were project-based and didn't cover overhead expenses such as salaries, which were picked up by the organizations themselves. This reduced the organizational capacity to run programs, though the report did show that programs were sustained for long periods of time on few resources (Hacking et al. 2006).

Another challenge was a lack of common language and understanding about the work. The National Health Service survey found that projects were often the brainchild of one person within the organization, suggesting a lack of collective practice in the field ("Art for Health: A Review of Good Practice in Community-Based Arts Projects" 2000). Stuckey and Nobel describe the challenge of comparing studies on the effectiveness of arts and health programs because there are no universal ways of describing the work and few cross-disciplinary studies (Stuckey and Nobel 2010). A similar idea is expressed in the Hanna report—she cites the challenge of a lack of cross-disciplinary work (Hanna 2011).

Many of the sources and studies I read attempted to create common understanding. Mike White sought to develop a code of practice for the field to make up

for the lack of a professional body providing this service, such as those that exist in the medical field (White 2010). An earlier paper for which White was a contributor says,

> What is now required in arts in health are well-designed longitudinal studies of the best established projects tracking their historical progression, along with evidence of their impact on their respective communities. We need work on clusters of such projects that pose similar research questions; that are willing to band together to try a common evaluation methodology within a large, externally-led research project; and that are then also willing to network with others to share practice and research outcomes (Macnaughton, White, and Stacy 2005, 338).

Finally, formal evaluation was a challenge for many programs. Hacking et al. reported that 61% of organizations surveyed regularly evaluated their programs but that the evaluations were mostly anecdotal and did not follow any kind of standardized instrument for measuring health and quality-of-life outcomes, though these tools exist (Hacking et al. 2006). The report said,

> Projects are keen to demonstrate the benefits of their work but are struggling in some respects to find ways of doing this. Only two projects indicated that they used a standardized, validated outcome measure at more than one point in time, although a third project used a range of scales that appear to be derived from standardized measures of well-being and self-esteem. Perhaps unsurprisingly, all three projects were located within or primarily funded by the health sector, where there are stronger

> traditions of formal evaluation than in other sectors (Hacking et al. 2006, 125).

In the National Health Service report, only 9% of respondents stated that thorough monitoring and evaluation was crucial to an arts and health program's success ("Art for Health: A Review of Good Practice in Community-Based Arts Projects" 2000, 18). Hanna, in her report, cited research challenges including small study populations and low visibility of research findings (Hanna 2011). The Arts & Health Alliance's prevalence study did find that formal evaluation was gaining traction over anecdotal evidence, but again I stress that all of the programs surveyed for that report were hospital-based rather than community-based, so the programs may have had an easier time making the case for formal evaluation and conducting formal studies (Sonke et al. 2009). It's also worth noting that evaluation is so standard in the health field that it is no surprise these programs are developing formal practices in this area.

Though a lot of resources are needed for evaluation, it can be attractive, and often required by funders to show that your programs have a real impact, plus evaluation can work as a tool for setting policy (Staricoff 2006). Hacking et al. stated that many arts organizations may benefit from some standardized evaluation procedures. While programs are all unique, Hacking et al. found that many programs were "reinventing the wheel" trying to measure similar outcomes such as "enjoyment or self-esteem" (Hacking et al. 2006, 126).

In addition to shared philosophies and challenges, studies found that many programs had shared common practices and program development methods. Judy

Rollins, a former board member of the Arts & Health Alliance, wrote a paper called "Arts Organizations and Public Health" where she laid out best practices after examining several arts programs that, with help from Partners for Livable Communities and the Ford Foundation, worked on projects to improve community health through the arts.

Rollins describes the first step toward crafting an arts for public health program as assessing community needs (Rollins 2011). This idea that targeted needs come first is echoed in much of the literature. The National Health Service report stresses that there is no "winning formula" for arts and health projects because they are specific and each community and patient population has different needs ("Art for Health: A Review of Good Practice in Community-Based Arts Projects" 2000, 29). Mike White cites a key factor of arts and health programs as putting participants first. Bernie Warren also says that practitioners must find out who comprises their primary audience to adapt the program to the audience's needs, both physically and mentally. This is different from the way many arts programs normally operate, as the impetus is to create art and not to meet external needs.

A second practice consideration is to recognize that arts and health work is creative and adaptive, as are the practitioners doing the work. Everitt and Hamilton found that programs were "emergent, innovative and experimental," in the sense that there were many paths to get to the same outcomes and programs were open to trying new methods and experimenting (Everitt and Hamilton 2003, 39). In White's 2010 article, he describes one guideline as being responsive to changing priorities and another as having "reflective practice"—critically examining past and present experiences and using the findings to

shape future practice. These suggest that practitioners be flexible and able to change their methods in the moment to adapt to the situation (White 2010, 151-153). This philosophy is different from the medical field, which values evidence-based approaches and consistent standards of care. In arts and health programs run by non-clinical practitioners, it is more important that the practitioner be attuned to his or her own self and the community in which he or she is working (Warren 2008).

Finally, partnerships were a huge component of arts and health practice in most of the literature I read. In the National Health Service report, the most cited factor for successful arts and health programs (27%) was strong/meaningful partnerships ("Art for Health: A Review of Good Practice in Community-Based Arts Projects" 2000, 18). When asked to describe the nature of the partnerships, 47% of organizations said they were about joint planning and management, 35% said they were about community consultation, and 30% said they were about shared resources ("Art for Health: A Review of Good Practice in Community-Based Arts Projects" 2000, 18).

Rollins wrote that the second step in creating an arts for public health program is to pull together a team made of community members, health institutions, government health departments, and others who can contribute to the project (Rollins 2011). In White's 2010 article he writes that the reason partnerships are so prevalent in community arts and health work is that arts practitioners are not clinicians. He writes,

> The problem with codes of practice…is that they are almost entirely directed at the artist, supplementing the requirements for a boldly competent arts practitioner with a whole raft of extra responsibilities

> relating to governance, research skills and partnership management that have to be 'adopted'. These are responsibilities that should be shared by project partners, with a support structure in place that enables the artists to concentrate on engagement with participants and delivery of the project, while allowing their input on the health and well-being aspects of the project to be explored and valued (White 2010, 146).

In my research I found two publications that specifically talked about best practices in arts and non-arts partnerships: Christopher Walker's paper "Arts and Non-arts Partnerships: Opportunities, Challenges, and Strategies" and Thomas E. Backer's paper "Partnership as an Art Form: What Works and What Doesn't in Nonprofit Arts Partnerships". Both texts stressed that, when partnering, major roles of each partner need to be clearly defined, a partnership mission and purpose should be written down, and both partners should take into account early in the partnership what potential risks exist, such as monetary costs, employee time needed, and power struggles (Walker 2004, Backer 2002).

# CHAPTER 1: FRAMING THE CASE STUDIES

## THE PROGRAMS

As I mentioned before, all of the programs I studied are housed within arts organizations whose primary mission is artistic. They are also mostly participatory arts programs, meaning that people who participate in the programs are actively engaged in an arts activity as opposed to being a passive audience. The one program that deviates from this is the Knoxville Symphony Orchestra's Music and Wellness program, which involves musicians performing for patients in hospitals. Still, I believe this is closer to a participatory activity because the musicians play in small groups for small groups of patients or individual patients, making it a much more active experience than sitting in a concert hall. What follows is a brief description of each of the programs I studied along with the names of the people I interviewed for each.

### *Case Study 1 – Porch Light*

Porch Light is a program of the City of Philadelphia Mural Arts Program, which had total assets of $6.4 million in 2013 according to their 990. Porch Light addresses behavioral health through public art. It was started in 2007 when Mural Arts engaged in a partnership with the city's Department of Behavioral Health and Intellectual disAbility [sic] Services (DBHIDS). In 2009, Mural Arts applied for funding to expand the program and won a grant from the Robert Wood Johnson foundation to complete three murals in three years. At that time, Mural Arts also reached out to the Yale School of Medicine to

complete a multi-year evaluation of the program's outcomes. Mural Arts continues to gain funding from organizations such as the Thomas Scattergood Behavioral Health Foundation. For the program, Mural Arts partners with health institutions that serve people facing behavioral health problems. With Mural Arts artists and the staff of these institutions, participants from these institutions design and create murals with themes centered on behavioral health. So far, 18 murals have been completed and there are six ongoing participatory mural projects, engaging more than 370 participants and 3000 community members. I interviewed Program Manager, Sara Ansell, former Chief of Staff Thora Jacobson, who no longer works for Mural Arts but was with the organization when Porch Light began, and Lindsay Edwards, Director of Creative Arts Therapies Department at the 11th Street Family Health Services of Drexel University, a partner in the program.

*Case Study 2 – Music and Wellness Program*

Music and Wellness is a program of the Knoxville Symphony Orchestra, which had total assets of $1.06 million in 2013 according to their 990. The Knoxville Symphony Orchestra serves 200,000 children and adults each year. They have a full range of educational and outreach activities; the Music and Wellness program is one that provides live music experiences to patients in hospitals and healthcare institutions. They partner with institutions in the Knoxville, Tennessee area, including their main partner, the University of Tennessee Medical Center. Recently, Knoxville received a Getty Education and Community Investment Grant to hire a part-time music therapist and advance the

program. The Music Therapist role is unique—she is employed by the orchestra but works in the healthcare institutions, sometimes along with the Symphony's musicians. The program employs small groups of musicians and some individual musicians. I interviewed the program administrator, Jennifer Barnett, Director of Education & Community Partnerships, and the Music Director and Conductor Lucas Richman.

*Case Study 3 – Extra Special Steps*

ESS is a Program of Steps Off Broadway, which is not listed on Guidestar. Steps Off Broadway is a small community theatre and performing arts education organization in Bellingham, Massachusetts. ESS is an 18-year-old program specifically for children with special needs that comprises multi-week sessions where students rehearse a musical and, at the end, they perform the musical for an audience in the company's 125-seat theatre. It is administrated by Arlena Boyle, who was the only person I was able to interview. She has the title of Co-Director, Dance and ESS Program, at Steps Off Broadway but also works as a speech pathologist. The program gains a small amount of earned income for Steps Off Broadway in student fees. They have gotten a couple of one-off grants from local entities, but nothing sustained.

*Case Study 4 – Dancing through Parkinson's*

Dancing through Parkinson's is a Program of Invertigo Dance Theatre, which had total assets of $68,178 in 2012, according to their 990. Invertigo is a small dance company in Los Angeles, founded in 2007, that performs and runs educational programs,

including the Dancing Through Parkinson's Program. It is a class for people with movement disorders such as, but not limited to, Parkinson's disease. The class was launched in early 2011 and is modeled after an international program, Mark Morris Dance Group's Dance for PD.[3] Classes are offered weekly in two locations and average 15-17 students per class. I interviewed the program administrator and Company Manager, Sofia Klass, as well as the board member who was the impetus for the program (and is a teacher herself), Linda Berghoff. There are no large grants that sustain this program—it is funded by individual donations and is free for participants.

## ORIGIN STORIES

The first question I asked all of my interviewees was how their respective programs started. This is not something I found in my literature review, and I felt it would reveal insights into how the arts and health field is growing. Many of the programs grew out of one person's impulse. Porch Light, for instance, started when the commissioner of the Philadelphia Department of Behavioral Health heard executive director Jane Golden speak about the impact of murals on the city's individuals and communities. Thora Jacobson, who was Mural Arts' chief operating officer at the time, indicated that many of the organization's programs began with an "inkling" from Golden. At the Knoxville Symphony Orchestra, music director Lucas Richman introduced the idea of the Music and Wellness program after he joined the organization from the

[3] Dance for PD runs dance classes for people with Parkinson's disease. They have grown to set standards, conduct research, and train other companies in this work. For more: http://danceforparkinsons.org.

Pittsburgh Symphony Orchestra, which had started a similar program (that program was also started by an individual, Penny Brill, who was a breast cancer survivor and violist). Invertigo Dance Theatre's program began when a board member, Linda Berghoff, was diagnosed with Parkinson's disease. Berghoff said that the program's origins were "personal. She [Laura Karlin, executive director and personal friend of Linda's] just wanted to do something for me." And, finally, Steps Off Broadway's Extra Special Steps program grew out of Arlena Boyle's experience as a speech pathologist and dancer. While she worked as a speech pathologist, she witnessed comprehensive therapy programs for students that included many of the same skills taught by theatre classes, and was inspired to try a theatre and dance program in a studio setting. She said, "In the therapy room activities were geared toward…opening up sensory stimulation through movement, jumping, swinging…I found that to be very positive in terms of making progress with my students."

In many of these examples, there is also a sense of "seeing to believe"—the people introducing the programs had seen something, whether it was in their own experience or another arts and health program, which proved to them that integrating the arts into health and healing could work. Both Knoxville and Invertigo crafted their programs from another organization's example: Knoxville used Pittsburgh Symphony Orchestra's program, also called Music and Wellness; Invertigo instructors were trained by the Mark Morris Dance Group, which runs an international program called Dance for PD. At Mural Arts, the process of creating murals had already proven to have some efficacy in community-building. Porch Light grew out of Mural Arts' work to ease

tensions in a Philadelphia neighborhood where African American residents clashed with Liberian immigrants. Thora Jacobson said, "it [Porch Light] started because of this one particular issue and they felt that it really worked to bring people together; there was less tension in the community, and they found shared perspectives and got shared resources."

## ORGANIZATIONAL CONDITIONS

Of the program managers I spoke with, many of them also commented on environmental- and mission-based characteristics of their organizations that contributed to the creation and growth of the health-related programs. Mural Arts' Sara Ansell said that all of the organization's program areas "try to move the needle for different issues. Mural Arts' greater vision is to use art for social change." At Invertigo, accessibility was a large part of the mission, and Sofia Klass indicated that this program was an extension of that because it is "about making dance accessible to people with Parkinson's disease." Arlena Boyle felt that the family-like, open nature of the Steps Off Broadway studio contributed to their willingness to work with her on the Extra Special Steps program.

Many of the people I spoke with also expressed personal beliefs in the general power of the arts to heal and affect change. Berghoff, from Invertigo Dance Theatre, said, "I've always believed in the arts, always… Until now, people thought of the arts as fluff but we in the arts know that there is more." Lucas Richman of the Knoxville Symphony orchestra said, "There is no question that the power of music can extend beyond the concert hall and touch our daily lives in whatever we do, providing multiple benefits as a source of healing and therapy." It is important to note that both of these people are highly

influential in their organizations—one being a board member and the other being the music director of the orchestra.

# CHAPTER 2: SIMILAR AND DISSIMILAR CHARACTERISTICS

## SIMILAR CHARACTERISTICS

One similarity between all of the programs I profile here is that they heavily stress the importance of differentiating their work from therapy. Every person I spoke with was adamant on this subject. Sara Ansell said that, while one of the Porch Light program's goals is to decrease symptoms, "we are not an art therapy program". Jennifer Barnett, Music and Wellness's program administrator, said that she would "never say [the program] is music therapy because we aren't always using a music therapist. I think this distinction really needs to be made between clinical training and not". Invertigo's administrator Sofia Klass said, "we don't say that the program is going to solve anyone's ailments or cure anybody. We don't even approach the class as therapeutic because we don't have that degree". Arlena Boyle of Extra Special Steps, even though she is a speech therapist herself, said that, while running the program, she is "using therapeutic techniques but I am not considered a therapist. I am a teacher".

When I asked what internal benefits the organization experienced as a result of the health-related programs, answers contained similar themes. Programs, perhaps because of the relationship to health, lent themselves to increased measurability and immediate and visible results. For Thora Jacobson, of Mural Arts, Porch Light represented the first time in the organization's history that a program garnered so much partnership support and potential for evaluation. She said, "the notion of there actually being a discernable change, one that one could calculate, quantify, was unlike anything

that had been done before. It was progressive, deliberately designed for change, and had very specific notions in mind". At Knoxville, Jennifer Barnett spoke about musicians delighting in immediate positive feedback that they did not necessarily get from other audiences. Arlena Boyle at Extra Special Steps said that "when you're in a situation when you see students achieving things that are beyond imaginable for them and the passion they have along with the disability… it is an overwhelming feeling of accomplishment and pride from the company that we can make something like that happen".

The programs energized artists and staff. At Knoxville, Jennifer Barnett noticed that the musicians employed by the orchestra started devising fundraisers on their own time to make improvements to the program. "This isn't something that happens with musicians ever," she said. Music Director Lucas Richman also said that performances in the concert hall were enhanced by the musicians' experience in the program: "As Music Director, I can certainly appreciate the increased depth of spirit and sound that now permeates our music-making". Invertigo's Sofia Klass said that teaching people with Parkinson's disease has enhanced her practice as a teacher, making her more patient and compassionate, and better at finding ways to make movement accessible but exciting, one of the major goals of the organization. At Extra Special Steps, Arlena Boyle saw students (from programs other than Extra Special Steps) stepping up to volunteer without being asked. She said, "they want to be part of such a positive program. We never say 'this isn't working out for us; we don't have time and resources. It's not worth it.' It is always, always worth it".

The programs also resulted in improved reputation for many of the organizations. Jennifer Barnett at Knoxville Symphony said that part of their strategic plan is to be relevant and important at home and on a national level. She says that the program brings national recognition because it is unique, and because Knoxville serves as a leader for other orchestras with fewer resources. At Invertigo, Sofia Klass says that people are often more engaged with the Moving through Parkinson's program than the company's other offerings. "[People] are almost more engaged when we talk about [this program] than when we say we're a professional performing dance company and we pay all of our dancers/employees. That isn't apparently as interesting as a class for PD," says Klass. I got the sense that this wasn't necessarily positive, but board member Linda Berghoff spoke about the program in a different light: "Really it has distinguished the company from other dance companies in the area. Many people do outreach, but no other company was doing anything with people with movement disorders. It's put us on the map". Berghoff also says that the company has been highlighted in the press and that the medical field has taken notice, with the University of Southern California reaching out to ask Invertigo to teach a class on site. At Extra Special Steps, Arlena Boyle says that the program inspires pride in the sense of community that is built among students.

Just one organization, Invertigo, cited increased audiences and individual financial support as a result of their program. This could be for a number of reasons—for one, the class is meant for an older audience, who also tend to have enough money to be donors and sustainers. It could also be the location in a large city (Los Angeles).

## DISSIMILAR CHARACTERISTICS

When talking about how the programs work, I also started to notice a divide between two sets of my case studies: the first set being Mural Arts and the Knoxville Symphony Orchestra and the second being Invertigo Dance and Steps Off Broadway.

First, the formalization of the programs was different. At Mural Arts and Knoxville, the work was clearly delineated as a program because it was unique enough to merit a new set of practices. At Mural Arts, Porch Light started as an initiative in 2007 but then grew into a program in 2009 when the organization gained a 3-year grant from the Robert Wood Johnson Foundation and, at the same time, engaged the Yale School of Medicine to do a multi-year evaluation of the work. “Without us even realizing it we had stumbled on a compelling formula. By giving it a title and identity [as Porch Light] we have thought a lot more intelligently about how we can do this work,” said Sara Ansell. Making it a full-fledged program has allowed the organization to dedicate staff and funding to Porch Light. At Knoxville, Jennifer Barnett said, “we knew it was more about investing in a long-term program and training for our musicians and looking at how we were meeting individual patients’ needs instead of serving hundreds of thousands of people”.

At Invertigo and Extra Special Steps, the program seemed to be more about modifying the organization’s existing practice for a new audience. “We approach it as a dance class modified for people with Parkinson’s,” says Sofia Klass. Arlena Boyle says, “Our productions are modified as much as I need to modify… We run as much of the class as possible as a typical dance and theatre program”.

Another area of difference was how each organization articulated their desired outcomes for the programs. For Mural Arts and Knoxville, goals were clearly defined and documented: Mural Arts had a logic model created for Porch Light highlighting goals on individual, community, and population levels and Knoxville had a strategic plan for Music and Wellness.

Interestingly enough, for both Mural Arts and Knoxville, there was also a layer of desired outcome for the healthcare providers themselves – to educate them about the efficacy of arts interventions in the hopes that these creative healing methods would be continued even without the presence of the arts organization. Lindsay Edwards, Director of Creative Arts Therapies Department at one of Mural Arts' partners, the 11th Street Family Health Services of Drexel University, said, "part of their [Mural Arts'] mission was to introduce this model and then you figure out a way to continue the work on your own so you don't continue relying on them…It has worked that way for sure. I can't speak to other agencies but it's been great in that way for us". At Knoxville, Jennifer Barnett said, "we felt like this is an important alternative integrative health idea that we could help introduce here [in local medical institutions] and an alternative that has had great results with patients".

This is reflected in one of the unique ways the Knoxville program works: in addition to their musicians playing in hospitals, they now also employ a music therapist on staff who supplements the work of the musicians by offering clinical services to patients as a music therapist. The therapist also acts as a facilitator between the patient and musicians—she will observe the patient's clinical state, for example by looking at a

cardiac monitor or the patients' facial expressions, and work with the musicians to tailor the pace or tone of their music to better suit the patients' physical state.

For Invertigo Dance Theatre and Extra Special Steps, however, the articulation of program goals was a bit less extensive and not at all documented beyond the ideas in the program manager's minds. The goals were also more closely aligned with the rest of the organization's goals, rather than being separate and distinct. At Invertigo, Sofia Klass said when asked what the outcomes of the program are, "I think, personally, as a teacher I want all my students to feel like they can move through their own life. That goes with Parkinson's disease and not. Discovering a joy for movement is really key… When I hear students experience that outside of class and they use the tools of dance to move through life that is really exciting for me". For Arlena Boyle of Extra Special Steps, she said that her main goal is for students to "get to the point of being independent and successful so that they can be integrated into a regular show or dance routine." She also admits "every kid's goal is different".

Differences lie, too, in the use of partnerships to run the programs. For both Mural Arts and Knoxville, partnerships are a huge part of the program's strategy, because partners help to supplement the knowledge that each organization lacks to make the program successful. Partners are also a large source of funding. Sara Ansell at Mural Arts says, "[Porch Light] has always been a partnership. The Department of Behavioral Health funds this work… They help us connect to provider agencies that we work with for each project. They help talk about our work to the field of behavioral health while we talk in the field of art". At Knoxville, Jennifer Barnett describes the collaborative way the Music

and Wellness program started, with a conversation between the symphony and invited health and community partners. “For us we wanted to really make sure it was a partnership…I have no training and expertise in this. To me a logical place to start was let’s talk to people already in the healthcare community or joining music with healthcare and get their insights”. Their program gets funding from the participating hospitals as well, so there is a monetary level to the partnership.

For Invertigo and Extra Special Steps, the program is run with virtually no help from partners. At Invertigo, there was even a sense of resistance to partnering with the medical field. Sofia Klass says, “It is really hard to be in contact with doctors. They may think the program is cool and advertise it in their office but they aren’t really interested in working with us. Some doctors come take our class, but we haven’t been advised”. She cites this as a positive for the program, saying that the absence of medical providers also gives them freedom. She differentiates between clinical interventions and arts interventions, saying, “I think that makes it a safer space for people because they [participants] are losing their ability to move functionally and dance is inherently movement-based and joyful”. Linda Berghoff, the Invertigo board member with Parkinson’s, did feel there were benefits in keeping medical practitioners involved. She said, “one hospital here, Cedars Sinai, has support groups and they brought us to their group and presented and the whole thing took off like wildfire. We couldn’t do it on our own. Doctors give us credibility and they want their patients to exercise. They help us get the population”.

Evaluation was also a source of difference between some of the programs. At Porch Light, a multi-year grant from the Robert Wood Johnson Foundation has allowed them to work with researchers from Yale University to evaluate the program, both in terms of Mural Arts' internal process and the outcomes that it produces for participants. For participants, Yale has conducted pre-participation and post-participation surveys and case studies of individuals to measure psychosocial metrics, such as feelings of empowerment and hope, and more medical metrics such as symptoms of depression and stress. The findings should be released in 2015 but a preliminary report, which I have included in my appendix, shows that the program does have concrete benefits such as promoting friendships, positive self-image, and reduced stigma against mental illness. According to Sara Ansell, this third-party evaluation affords Mural Arts a lot of freedom, "the work of Porch Light is not to create instruments, it's to do art and someone else will come in and start measuring".

At Knoxville, they have not yet evaluated the program but they plan to in the near future as a result of the Getty grant. When asked why, Jennifer Barnett said, "it is important in the growth of the program. Medical people are so focused on results. We need quantitative data to reference when we are talking to them". I did not get information from Barnett about how the evaluation would be built, but I did find a document published by the Pittsburgh Symphony Orchestra, a pioneer in the area of symphony-based music and wellness programs, that presents logic models and indicator samples that organizations can use to evaluate their programs and outcomes, including the percent of patients who report personal benefit from the program, the number of

musicians who want to participate in the program, and an increase in funding as a result of the program.[4]

At Invertigo, evaluation was not a priority due to lack of resources. Sofia Klass said, "If someone wants to do some research and it isn't going to affect us but help us, I don't know if we'd say no to that. We just don't at the moment have the impetus to do that". And at Extra Special Steps, Arlena Boyle questioned the value of research to the program's audience, though she did feel that with the resources she'd like to evaluate the outcomes of her program. She said, "I think [some parents] would just want their kid to have fun. When I think about a swim class as a parent, I wouldn't really want to make sure that my kid is specifically treading water. I would want to see progress but ultimately I want them to have fun and be safe in the water".

In terms of funding, both Porch Light and Knoxville had large, multi-year grants that positively affected the robustness of the programs. Sara Ansell indicated that she spent a lot of time thinking about how to cultivate more funding and a more diverse funding base, in addition to Robert Wood Johnson and Scattergood. At Invertigo and Extra Special Steps, there were no large grants for the programs; I should note again that Invertigo's classes are free and Extra Special Steps charges a modest fee for students.

[4] The full manual provided by the Pittsburgh Symphony Orchestra can be found here: http://wellness.pittsburghsymphony.org/wp-content/uploads/2013/08/Full-Music-and-Wellness-Program-Handbook.pdf

# CHAPTER 3: OTHER CONSIDERATIONS

There was a lot to discover in my interviews and I want to highlight some extra findings that I feel were important but did not fall into the above categories. First is that, for all the programs, when asked how they define the work they do there was a sense of the arts and health aspects being truly intertwined and difficult to separate. At Porch Light, Sara Ansell said that they talk about the program as "being at the intersection of public art and public health. It's a public art program first and foremost but it's intended to benefit health". She even questions the definition, though, saying, "this work is groundbreaking and it's a leap for the field of behavioral health. Or, the field of public art. Where does this fall? What is this about"? At Knoxville, the program is defined as "arts and health," which is interesting because Knoxville is also the most closely aligned organization with the Arts & Health Alliance. Arlena Boyle at Extra Special Steps, who is both a dancer and speech pathologist, talked about her role in the program saying, "I don't think I've ever separated my backgrounds. When I speak to parents I say my background is in speech pathology but I've danced all my life… It's hard to separate the two given the program. I am kind of both when I'm there".

I was interested to know how the programs talked about participant outcomes, because this is something the health field is very good at measuring but it has not historically been a conversation in the arts field. Given that these programs are health-related, I felt it was important to hear each program talk about their desired outcomes. Many cited what my literature review called "social determinants" of health. At Porch

Light, Sara Ansell used the word explicitly, saying, “If you think of health holistically and social determinants of health and how built environment affects health we absolutely intersect with those”. This was also apparent in Invertigo’s answers. Sofia Klass said that she was hoping for her students to feel confident and empowered through dance. She also stated that it was important for participants to learn to “create movement… You [Parkinson’s patients] are losing your ability to move and then dance gives insight into how to put movement together”. Board member Linda Berghoff said that students, “come in tired, some stiff, and they all say they feel better afterward”. For Arlena Boyle, measuring outcomes was not as vital to her work as just seeing students be successful in the program. She says, “in the therapy world, data is what we really need. In this role, I don’t collect data because I’m not doing therapy, per se. I am using therapeutic techniques but I am not considered a therapist. I am a teacher. I am measuring progress in terms of how they are successful in the classroom”.

It seemed that only Porch Light had formal outcome articulation in the form of an extensive logic model document that Sara Ansell shared with me, which I have included in the appendix. This logic model was developed in conjunction with the Yale School of Medicine, which is working with the program to assess its impact. Ansell did say that, “my job is to implement program what Yale can measure, it’s not to come up with this instrument”.

For the Knoxville Symphony Orchestra, the outcomes were a bit more clinical, which may be due to the program’s close relationship with hospital partners. When I first asked Jennifer Barnett about outcomes, she talked only about the hospital’s desired

outcomes, which she said were related to patient satisfaction. When I pressed on about internal outcomes, she said, "We have been training some musicians as certified music practitioners. They have training in how to observe and tailor what they're playing to the needs of the patient. We want them to really benefit patients".

As I had previously worked with the Arts & Health Alliance, I wanted to find out from my interviewees how attached they felt to the larger community of arts and health practitioners. At Porch Light, Sara Ansell said they were not in any active conversations, but she felt they would find value in joining a larger dialogue about public art and public health. When I asked if they used any third-party resources to inform the program, she only cited the program's existing partners and funders. Knoxville is closely aligned with the Arts & Health Alliance—they have been members for several years and, in 2005, had a grant from the organization to help with strategic planning of the Music and Wellness program. Barnett also received a certificate for an intensive Arts in Healthcare program at the University of Florida Center for Arts in Medicine, saying, "I wanted to be trained as an administrator too in addition to the musicians". Barnett says she communicated with other symphony-based wellness programs, though most of them contact her because they are interested in the model. She said, "In some ways I feel like we are alone in the symphony world because others have not been doing this work as long as we have". This past year, administrators from Invertigo attended the Arts & Health Alliance conference, and Sofia Klass indicated that she felt engaged with the larger community. At Extra Special Steps, however, Arlena Boyle said, "I really think we are isolated. That doesn't sound very good. We haven't made any efforts to connect with other places". She was

not aware of any overarching organizations that she could connect with, as there were in the world of speech pathology. "I mean I guess there isn't even a title for this kind of thing? It is not a career in itself. Even if you pulled all those different people together they would have different words for it… It would be interesting to know what other studios do something like this. I'm sure this area is even bigger than we would imagine. There is no org that kind of puts us under an umbrella that we could attach to".

I also spoke with many interviewees about how they balance the aesthetic qualities of art with the health-related missions of their programs. This seemed to be an important issue. At Porch Light, Sara Ansell talked about the extensive process that murals go through for quality check before they are green-lighted by internal stakeholders, artists, and the community. At Extra Special Steps, Arlena Boyle talked at length about her desire to produce high-quality productions with her special-needs students. Many of her reasons centered on the parents and students she worked with. She said, "I am extremely critical… I always feel like I want the parents to feel like the money they spent on the program was worthwhile… I demand that it look good because it has to. [Students] have to feel what it's like to be part of a real show".

# DISCUSSION

In my introduction and literature review, I discussed my preconceived notions about what my case studies would reveal. These included tensions between therapists and artists, struggles with evaluation, and organizations engaging in partnerships to supplement the health knowledge that they lacked. Though these issues all appeared in my case studies (probably due to the questions I asked), I found that only a few topics presented similarly across the board, and many issues presented differently.

In similarities, I first saw that a lot of the programs started because of one individual who straddled two worlds, like myself. This was either someone who was both an artist and a patient or an artist and a practitioner. People were also inspired after seeing another program in action. I believe that, as programs spread and become more visible, the prevalence of these programs in the U.S. will grow exponentially as arts organizations see other arts organizations celebrating successes.

Second, differentiation between therapy and non-clinical arts and health work was important to all of the programs, speaking to the tensions between these two ways of working. After conducting all of my interviews, I spoke with Patricia Dewey, the director of the University of Oregon's Arts and Administration Program, which just recently introduced Arts in Healthcare Management Concentration. On this topic, she expressed the opinion that "the field of general arts and health… is growing by leaps and bounds while the creative arts therapies are not. And so that is what the issue is all about". I

think, perhaps, it is true that the general field of arts and health is growing and getting more recognition while the creative arts therapies have been around for more than half a century. I also think the problem lies in the language used—the media is not clear on what constitutes "therapy" and often will call artist-led programs therapy, which trivializes the time and energy that actual creative therapists spend obtaining their credentials. Dewey agrees with me, though, in saying that therapists and non-therapists can co-exist in the field, as long as there is widespread education about the different types of roles each can fill and the appropriate ways to talk about the work. Knoxville Symphony Orchestra, in engaging both musicians and a clinically trained music therapist, has found a way to successfully use both simultaneously in different roles. They can and should serve as an example to the field of how the two practitioners can fit together.

All of the programs also afforded similar self-reported benefits to the organizations, including that the programs produced quick and visible positive effects on participants, that staff and artists were energized by the work, and that the program gives the organization a good, if not increased, reputation. Only one organization, Invertigo, cited monetary benefits from their program, but none of the other organizations seemed to care that the programs did not increase earned revenue or donations. Of course profit is not generally the most important thing to arts nonprofits, but I do think it is important to note that the programs were important to the organizations for reasons other than financial gain.

What I found much more interesting in my research was the major differences between the organizations that I studied. It became abundantly clear to me that there was

a rift between the two larger programs I studied, Mural Arts' Porch Light and Knoxville Symphony Orchestra's Music and Wellness, and the two smaller organizations that I studied, Steps off Broadway's Extra Special Steps and Invertigo's Dancing through Parkinson's. I call both Porch Light and Knoxville larger because they have more funding, staff, and resources at their disposal than Invertigo and Extra Special Steps. The difference in size was a factor not only in the way the programs operated, but also in the organization's valuation of processes such as evaluation and outcome articulation.

One of the major differences in the programs was formalization—both Porch Light and Music and Wellness were clearly delineated programs of the parent organization and, while Dancing through Parkinson's and Extra Special Steps were programs with their own titles, they were described more as extensions of the organization's other artistic work than as unique and standalone practices. When it came to documenting the way the programs worked and the outcomes the organizations wished to achieve, Porch Light and Music and Wellness were also more formal, presenting me with logic models, strategic plans, and other well-thought-out answers. They were even going so far as to try and change attitudes in the healthcare sector through their programs, which is an ambitious undertaking for an arts organization. For Dancing through Parkinson's and Extra Special Steps, the documentation was non-existent outside of the program managers' heads.

Partnerships were another area of difference. Porch Light and Music and Wellness relied on partnerships with health institutions to run their programs; the programs geographically were run outside of the organization in health institutions, so clearly the

partnerships were vital to the programs' function. Dancing through Parkinson's and Extra Special Steps did not engage much, if at all, with partners other than to build audiences.

Finally, there were major differences in the organization's evaluation procedures. Porch Light, from the beginning, sought out a partner for evaluation and found the powerhouse of the Yale School of Medicine. Music and Wellness gained the support of the Getty Foundation and has plans to investigate the program in the near future, though it hadn't been done before. Without the support of major funders, Dancing through Parkinson's and Extra Special Steps have never conducted evaluation and don't express any impetus to do so in the near future. They both expressed that, with unlimited resources, it is something they're interested in, but I got the sense that it was not a priority even if they were lucky enough to get the resources.

## LIMITATIONS AND FURTHER RESEARCH

This study was not a prevalence study or a mapping of the field in the U.S. and I feel that this is badly needed to be able to understand the scope of programs both in and outside of healthcare settings. Katie White's research at the University of Oregon is a start, but she indicated to me that she had trouble reaching programs and I would strongly urge the Arts & Health Alliance to assist her in her research and connect her with other field-wide organizations such as the Joint Commission and Americans for the Arts to pursue a larger-scale survey. I would encourage the Arts & Health to absorb or subsidize Katie White's work, as it would be a worthwhile venture for them to pursue and would help them serve the field better. White's project can be found here, on the blog of the

University of Oregon's Arts in Healthcare Research Consortium: http://blogs.uoregon.edu/artsinhealthcare/. A field-wide survey that included detailed information about the programs, much like the studies done in the U.K., would be better positioned to draw conclusions about the issues I've touched on here, because it would find whether those issues are repeated on a larger scale.

If you want to know more about the field and its history, I recommend visiting the Arts & Health Alliance's new web page: https://www.artsandhealthalliance.org. Though I express in this paper that the organization has a lot of work to do, I still very much believe in their mission and know that all of the people involved in that organization, including board members and staff, are well-intentioned and passionate about the field. Plus, they offer a wealth of resources that can be found if you look hard enough (in the Resource Center on the website there is a "Tools for Practice" section where I believe these overarching tools reside).

To learn more about the Arts & Health Alliance's equivalents in other countries, I suggest looking at the U.K.'s National Alliance for Arts, Health and Wellbeing (http://www.artshealthandwellbeing.org.uk) and Arts and Health Australia (http://www.artsandhealth.org). I also think the recent "Creative Minds in Medicine" report out of Cleveland, which chronicles the arts and health work being done in that region and the partnerships being forged to do this work, is an important model for how other cities can assess localized arts and health programs and potential for programs. That report can be found here: http://www.cultureforward.org/Reference-Desk/Research-Library/Health-and-Human-Services/Creative-Minds-in-Medicine. Cleveland is working

hard to establish itself as an important city for both arts and medicine, and I am pleased to see that they are using this interdisciplinary work as a way to do that. Other cities should follow their example and inventory and support the arts and health work being done.

# CONCLUSION

I came into this research thinking I could glean best practices from my case studies and formulate recommendations for arts administrators. I came out of my research not even thinking about best practices and recommendations, and instead feeling like there were fundamental issues in the framework in which I believed all arts and health programs operated. Working for the Arts & Health Alliance, I was constantly thinking in a medical framework. One of the organization's major goals is to show the world that the arts are, in many ways, as effective and worthwhile as traditional medical interventions, and that requires using the language of the medical field to talk about arts and health. We focused heavily on creating field-wide standards for practice and ethics, highlighting research, and assisting programs with evaluation to prove their effectiveness in treating specific ailments. I do not disagree with these goals at all—if the medical establishment believes in the value of the arts as a treatment option, it will benefit anyone who is practicing arts and health in any capacity, even outside the hospital setting.

But the downside to the Arts & Health Alliance's focus on "medicalizing" the field may be that they are losing sight of work being done outside of that framework, which is just as important to the field as other work. In my research specifically, I found two organizations that are doing meaningful work that I consider to be in the realm of the arts and health field (Invertigo Dance Theatre and Steps Off Broadway), but they lack the resources to and, more importantly, aren't very eager to do things the way the medical field would. They are satisfied with running health-related programs as an extension of

their current artistic practice, and the "proof" that the programs are "working" is simply that participants are happy and continuing to participate. I have no doubt they are producing positive results, but they don't feel the need to justify their existence in that way.

I see the values of the Arts & Health Alliance at odds with the values of the programs at Invertigo and Steps Off Broadway, and I don't think the field can advance or grow until the Arts & Health Alliance steps back and takes inventory of the work being done, to really understand where the field is and what all of its practitioners, not just those in hospitals, need. Katie White's mapping project is certainly a start, but I think the Alliance could do more not just to find prevalence but also do a needs assessment for the field. They do conduct a member survey every year but it is more about having members rate the resources the Alliance is offering, and not generally about what the field needs that the Alliance is not doing.

For arts organizations doing health-related work, I think it is important to show them that there are many acceptable models to follow when crafting programs, some of which are not medically inspired. Mentorship and some kind of collective that encourages sharing of back-end administrative and research services would also be useful; there is a lot that an organization like Steps Off Broadway could learn from an organization like Mural Arts, and they might also be able to benefit from the study that the Yale School of Medicine is designing for Mural Arts. I also think it is important to recognize that, unlike hospital-based programs, arts organization-based programs are not necessarily making health outcomes their main priority. As my interviews with

Invertigo's program director revealed, some arts organizations want to be recognized for their artistic endeavors just as much if not more than their health-related programs.

When speaking with Patricia Dewey about field-building, she brought up the point that "programs run by arts organizations in the community may not tap into the Alliance as naturally as people who are working directly with hospitals and other health institutions." So one concrete thing I would urge the Arts & Health Alliance to do would be to seek out better ways to reach these people and bring them into the community. A huge way to do that would be to establish a chapter system that could proliferate in cities and regions across the country, with passionate people leading the charge outside of the Alliance's national office. This would really allow them to get on the ground despite having very few resources on the national level.

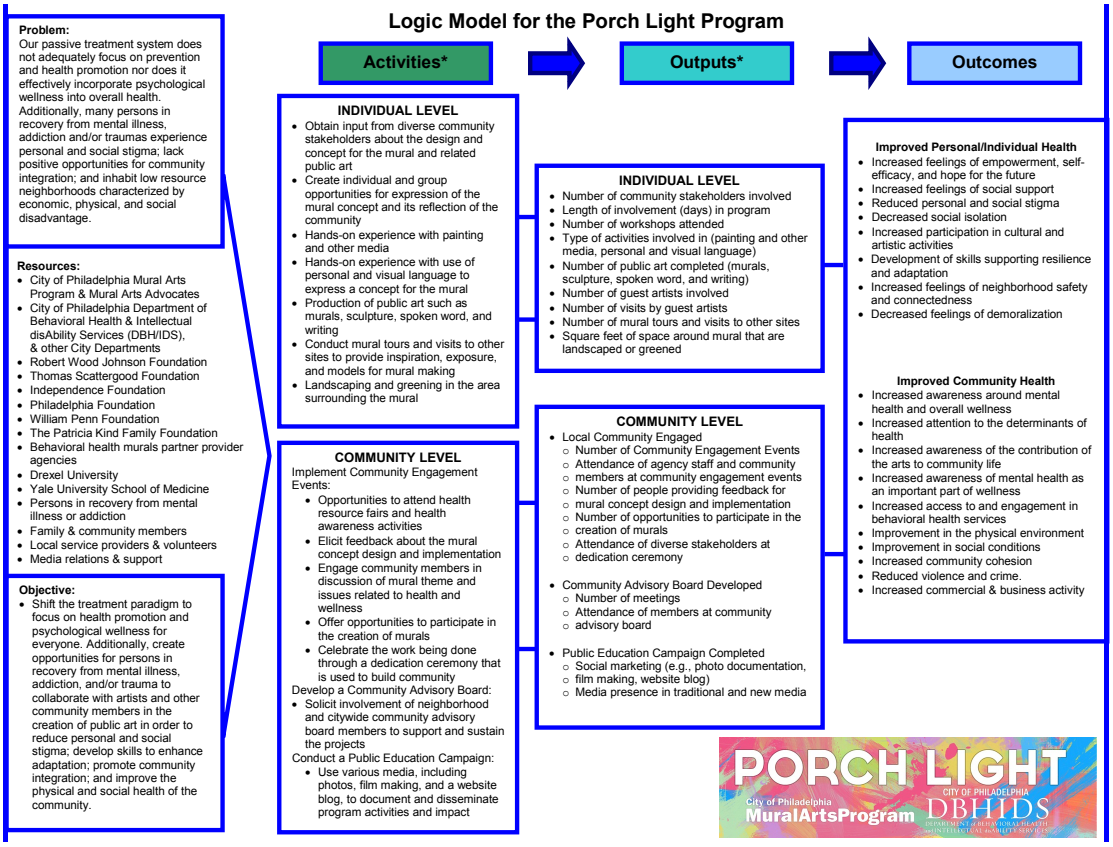
In the arts field as a whole, I see that there is mounting pressure to prove the impact of programs beyond art for art's sake. I felt, at the beginning of my research, that arts and health programs would fall squarely in this realm of instrumental arts programs—ones that use the arts to achieve some other end. But, interestingly enough, I found that there are organizations that are doing "arts and health programs for arts and health program's sake." Just as there has to be room for both in the arts field as a whole, there has to be room for both in the arts and health field. The Arts & Health Alliance should find ways to balance moving the field forward professionally and serving arts and health programs in all of their iterations.

# APPENDIX A: INITIAL LIST OF ARTS ORGANIZATION-BASED PROGRAMS

List of programs

| Program name (if any) | Arts Org | Location | Website |
|---|---|---|---|
| Music and Wellness Program | Knoxville Symphony Orchestra | Tennessee | http://www.knoxvillesymphony.com/education-community/music-and-wellness-program/ |
| Artful Healing | Museum of Fine Arts Boston | Massachusetts | http://www.mfa.org/programs/community-programs/artful-healing |
| Movement E-Motion | AZ Dance | Arizona | http://www.azdance.org/outreach.html |
| Porch Light | Mural Arts | Philadelphia | http://muralarts.org/programs/porch-light |
| Musicians Care | Elgin Symphony Orchestra | Illinois | http://www.elginsymphony.org/EDUCATION/community.html |
| Dance for PD | Mark Morris Dance Group | NY/Worldwide | http://danceforparkinsons.org/about-the-program |
| Autism Drama Program | Theatre Horizon | Philadelphia | http://www.theatrehorizon.org/education/autism.html |
| Music & Stress | Portland Symphony Orchestra | Maine | http://www.portlandsymphony.org/content/education/in-our-community/ |
| Meet Me at MoMA | Museum of Modern Art | NY/Worldwide | http://www.moma.org/meetme/index |
| Heartstrings | Madison Symphony Orchestra | Wisconsin | http://www.madisonsymphony.org/heartstrings |
| Picture This!/Flash Drive | Houston Center for Photography | Texas | http://www.hcponline.org/community |
| Dancing Through Parkinson's | Invertigo Dance Theatre | California | http://www.invertigodance.org/parkinsons |
| Hospital Outreach Program | Tucson Museum of Art | Arizona | http://www.tucsonmuseumofart.org/learn/community-outreach/ |
| Act II: Aging Creatively Through the Arts | Solon Center for the Arts | Ohio | http://www.solonohio.org/index.aspx?NID=678 |
| Moving Connections | Verb Ballet | Ohio | http://www.verbballets.org/connections.html |
| The Memory Ensemble | Lookingglass Theatre | Chicago | http://www.brain.northwestern.edu/support/enrichment/memory_ensemble.html |
| Kids Together Against Cancer | Cummer Art Museum and Gardens | Florida | http://blog.cummer.org/2011/01/kids-together-against-cancer/ |
| ArtHaven | Leepa-Ratner Museum of Art | Florida | http://newsspc.wordpress.com/2013/06/26/lrmas-role-in-local-health-care-showcased-in-national-report/ |
| ? | Barn Theatre | Minnesota | |
| Drama Class | Theatre for Everyone (classes) | NJ | http://www.papermill.org/education/theater-school/youth-theatre.html |
| First Stage | Next Steps | Milwaukee | http://www.firststage.org/Our-Academy/Next-Steps/ |
| Steps off Broadway | Extra Special Steps | Massachusetts | http://www.stepsoffbroadway.com/ess.html |

# APPENDIX B: MURAL ARTS LOGIC MODEL



# APPENDIX C: MURAL ARTS PRELIMINARY RESEARCH FINDINGS

## *Preliminary Findings – Porch Light Program Evaluation*

Since we began the project, we have a more realistic expectation of what Porch Light can offer to individuals and communities, and what it cannot expect to do. Many of the participants in Porch Light face extraordinary personal and social challenges to live a satisfying and productive life. In addition to challenges with psychiatric symptoms and/or recovery from addiction, participants are often unemployed or underemployed, struggle financially, live in neighborhoods characterized by violence and crime, and have a diminished network of friends and social supports. For the most part, Porch Light cannot fundamentally address these challenges. However, **what Porch Light has the potential to do is to set in motion a series of positive and constructive experiences for participants and within communities that, under the right circumstances, can lead to increased stability in one's life and to change the trajectory of that life in positive directions.** The case studies clearly demonstrate that, and preliminary quantitative findings hold promise as well for these sorts of impacts. Of particular interest when most findings from the evaluation come in next Spring will be whether there is an interaction of impacts between individual-level outcomes and community-level outcomes, and whether outcomes are sustained over time.

The following are results based on a) examination of selected change scores from baseline and posttest for 76 participants who have completed individual interviews, and, 2) detailed qualitative case studies of several participants who have completed the Porch Light program.

Our logic model specifies increases in recovery-oriented measures (empowerment, hope) as well as measures of functioning and well-being (overall symptoms, depressive symptoms, and perceived stress) following program participation. Since the sample of program and comparison participants is too small to detect any effects at this time, **we examined whether the differences from baseline to posttest scores for the 76 individuals available are consistent with expectations in our logic model.** Specifically, we expect that increases in recovery measures (empowerment and hope) will be negatively correlated with problematic functioning measures (overall symptoms, depressive symptoms, and perceived stress); that is, **over a period of 5-10 months, as recovery scores go up, symptoms should go down. In fact, this is exactly what we found.** For example, **as hope is increased over time, overall symptoms and depressive symptoms go down** ($r = -.31$, $p < .01$; $r = -.30$, $p < 01$, respectively) and perceived stress is reduced ($r = -.23$, $p < .06$).

A similar pattern of findings emerges for empowerment scores. These findings suggest that **the extent to which participation in Porch Light promotes hope for the future and one's capacity to shape that future through feelings of empowerment and personal agency, symptomatic behavior should either be reduced or remain stable.**

Evidence from our intensive, qualitative case study interviews of Porch Light participants is consistent with these analyses. Thus far, we have completed follow-along interviews with 8 participants, and are currently summarizing these for presentation and publication. Core qualitative findings indicate that **Porch Light results in at least five common changes among participants.** First, Porch Light creates a supportive community that promotes friendship. Second, through participation members develop an enhanced, more positive sense of themselves and their competencies. Third, by working alongside others in recovery as well as artists, staff, and community members who are not in recovery, participants feel a sense of normalcy and reduced stigma. Fourth, creating art that has an explicit public purpose helps participants feel that they are giving back to their community in a positive way. And finally, participation in Porch Light increases participants' hope for the future. These five factors – **promoting friendship, enhancing one's sense of self, reducing stigma, giving back to the community, and increasing hope** – are evident to varying degrees in each of the case study interviews, and provide qualitative support for the impact of Porch Light on individuals.

# BIBLIOGRAPHY

"Art for Health: A Review of Good Practice in Community-Based Arts Projects." 2000. National Health Service Health Development Agency.

"Arts & Health." 2011. *Global Alliance for Arts & Health*. http://www.thesah.org/template/page.cfm?page_id=604

Backer, Thomas E. 2002. "Partnership as an Art Form: What Works and What Doesn't in Nonprofit Arts Partnerships." *John S. and James L. Knight Foundation. Retrieved April* 21: 2008.

The Center for Performance and Civic Practice. "About." Accessed October 19, 2014. http://www.thecpcp.org/about/

"Creative Minds in Medicine." 2014. Community Partnership for Arts and Culture. http://www.cultureforward.org/Reference-Desk/Research-Library/Health-and-Human-Services/Creative-Minds-in-Medicine.

Everitt, Angela, and Ruth Hamilton. 2003. "Arts, Health and Community." *A Study of Five Arts in Community Health Projects. Durham: CAHHM*. https://www.dur.ac.uk/resources/cahhm/reports/Arts Health %26 Community.pdf.

Hacking, Sue, Jenny Secker, Lyn Kent, Jo Shenton, and Helen Spandler. 2006. "Mental Health and Arts Participation: The State of the Art in England." *The Journal of the Royal Society for the Promotion of Health* 126 (3): 121–27.

Hanna, Gay. 2011. "The Arts and Human Development." National Endowment for the Arts.

Macnaughton, Jane, Mike White, and Rosie Stacy. 2005. "Researching the Benefits of Arts in Health." *Health Education* 105 (5): 332–39.

McCarthy, Kevin F., Elizabeth H. Ondaatje, Laura Zakaras, and Arthur Brooks. 2001. *Gifts of the Muse: Reframing the Debate about the Benefits of the Arts*. Rand Corporation.

Rollins, Judy. 2011. "Arts Organizations and Public Health". Partners for Livable Communities.

Sonke, Jill, Judy Rollins, Rusti Brandman, and John Graham-Pole. 2009. "The State of the Arts in Healthcare in the United States." *Arts & Health* 1 (2): 107–35.

Staricoff, Rosalia Lelchuk. 2006. “Arts in Health: The Value of Evaluation.” *The Journal of the Royal Society for the Promotion of Health* 126 (3): 116–20.

Stuckey, Heather L., and Jeremy Nobel. 2010. “The Connection Between Art, Healing, and Public Health: A Review of Current Literature.” *American Journal of Public Health* 100 (2): 254–63.

Walker, Christopher. 2004. “Arts and Non-Arts Partnerships: Opportunities, Challenges, and Strategies.” http://www.urban.org/url.cfm?ID=311043.

Warren, Bernie. 2008. *Using the Creative Arts in Therapy and Healthcare: A Practical Introduction*. Routledge.

White, Katie. “Mapping the Arts in Healthcare Field: Programs, Resources, and Growth Trends in the United States.” Master’s Thesis, University of Oregon, 2014.

White, Mike. 2002. *Determined to Dialogue*. Center for Arts and Humanities in Health and Medicine. http://www.ilg.org.uk/resources/cahhm/reports/Determined to Dialogue Last.pdf.

———. 2009. *Arts Development in Community Health: A Social Tonic*. Radcliffe Publishing.

———. 2010. “Developing Guidelines for Good Practice in Participatory Arts-in-Health-Care Contexts.” *Journal of Applied Arts & Health* 1 (2): 139–55.